Long Term Care Covid-19 Commission Mtg.

Drs. Nathan Stall and Alison McGeer
on Tuesday, January 19, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 19th day of January, 2021, 10:30 a.m. to 11:35 a.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

Dr. Allison McGeer, M.D, FRCPC
Infectious Disease Consultant, Sinai Health System
Professor, Departments of Laboratory Medicine and Pathobiology and Dalla Lana School of Public Health, University of Toronto

Dr. Nathan Stall, MD, FRCPC
Geriatrics and Internal Medicine (Clinical Associate) Sinai Health System and the University Health Network Hospitals Women's College Hospital.
PhD Candidate, Clinical Epidemiology & Health Care Research Institute of Health Policy, Management and Evaluation Women's College Research Institute
Eliot Phillipson Clinician-Scientist Training Program University of Toronto

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

Derek Lett, Policy Director Long-Term Care Commission Secretariat

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Angela Walwyn, Senior Policy Analyst Long-Term Care Commission Secretariat

John Callaghan, Co-Lead Commission Counsel Gowling WLG

Lynn Mahoney, Counsel Gowling WLG

Peter Gross, Counsel Gowling WLG

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

I N D E X

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: 33, 58

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages: None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: None

-- Upon commencing at 10:30 a.m.

JOHN CALLAGHAN: Dr. Stall, are you able to run the slide deck, or do you need someone to do it?

NATHAN STALL: I can do that.

JOHN CALLAGHAN: Okay. Thank you. Just -- I don't think either -- both Dr. McGeer and Dr. Stall have appeared before, and neither needs an introduction.

For the benefit of Dr. McGeer and Dr. Stall, the Commission has heard, just before this presentation, from a long-term care home about its trials and tribulations about vaccinations, so they've heard -- they've heard some information, and, in fact, that home, notwithstanding the challenges, seems to have done very well, but nonetheless, outline the challenges.

So just so you know, they're -- they may ask questions that have been informed by that prior presentation. But go ahead when you're ready.

NATHAN STALL: Sounds good. So thank you very much for having Dr. McGeer and I at the Commission today. We are, you know, pleased to present about the vaccine rollout. Even though

it's in its initial phases, I think there are some concerns, learnings, and action items which could accelerate the vaccine program and prevent long-term care home resident cases and deaths.

So Dr. McGeer and I will speak to each of these points. We are going to talk about what the issues are in terms of the rollout. We will talk about what could have been done to have vaccinated more long-term care homes by this point, what we can do now, and I will present some modeling data that I've done with colleagues looking at simulations of long-term care residents' cases and deaths under three different rollout scenarios.

So what we'll start is talking about sort of what we perceive to be seven of the major issues confronting the vaccine rollout. The first is the slow speed of rollout and the perceived lack of urgency.

So we have had vaccine. You'll know that the first person vaccinated in our province was on December 14th, 2020, was a personal support worker of a long-term care home. And, you know, to date, as we'll get to, we don't actually even know, from publicly reported data, how many long-term

care home residents have been reported, but there -- it's been reported in the media that there's about 40,000 long-term care and retirement homes that -- doses that have gone to those settings. Some of those will -- the majority, we would anticipate, would include residents, but there are also caregivers and staff in there.

So, you know, considering that there are 70,000 long-term care home residents, about 60,000 of retirement home residents, we know that the minority of long-term care home residents have been vaccinated to date, and that lags behind other provinces like Alberta which have provided COVID vaccine to all of their long-term care residents as of yesterday. Quebec has done about three-quarters of them, and British Columbia plans to finish vaccinating all their long-term care home residents by next week.

Dr. McGeer, did you have more to add about that?

ALLISON MCGEER: Yeah, I -- to me, the comparison of what we have done and what is possible is the illustration of those homes for which Michael Garron was responsible. Michael Garron started preparing for the vaccine

rollout at the beginning of December as expected. They completed vaccination of all 23, so that's 23 of roughly 160 or 170 long-term care and retirement homes in Toronto. The 23 that Michael Garron are responsible for, they finished vaccinating on January the 5th. That's what was possible.

COMMISSIONER FRANK MARROCCO (CHAIR): And those are the 23 in the catchment area for the hospital; is that the idea?

ALLISON MCGEER: Yeah. Yeah. So each -- right -- in the -- as the second wave started, the Ministry went back to assigning hospitals for, you know, support for different long-term care facilities and retirement homes. So every hospital in Toronto is responsible for a group -- support for a group of long-term care and retirement homes. And Michael Garron just quietly organized vaccination for that group.

They brought buses. They rented TTC buses to come in to pick up long-term care workers and bring them in while they were on shift so that they didn't have to travel and deal on their time off. They sent physician teams out to the homes to support delivery of vaccination. You know, it's a marker of the fact that this is not -- yeah, the

team at Michael Garron is good, okay? But this is not rocket science. This is not complicated. If you take a bunch of people who understand vaccination programs and have run them before, it can be done.

They -- even they were impeded by, as Nathan points out in point 3 -- sorry, point 2 -- the issues of transporting the Pfizer vaccine which stymied us in Ontario for much longer than it did in other provinces and other countries. It's -- I think that issue is complicated but still clearly something that many other people got past that we were unable to get past.

COMMISSIONER JACK KITTS: So is -- did Michael Garron set up its own process and did its own thing? Or were they part of a broader standard process?

ALLISON MCGEER: Hospitals were -- hospitals, you know, we agreed on priorities. We had a group of 19 hospital hubs, and I -- it's not actually clear to me. I think it has not been transparent what instructions hospital hubs got and how they managed them. They certainly got some fairly specific instructions from the Government about what to do, but -- and I suspect that

Michael Garron skated around the edges of some of those instructions in what they were doing. I wouldn't be surprised if they hadn't had a few angry phone calls from people about some of it. But, you know, it does not appear to have done permanent harm to them, and I think hospitals were substantially left on their own to organize delivery of vaccine to their long-term care homes.

COMMISSIONER JACK KITTS: Okay. And the 19 hospital hubs, does that cover the Province, or is that the Toronto area?

ALLISON MCGEER: That covers the Province.

COMMISSIONER JACK KITTS: So 19 hospitals were given the same, I guess, instructions and authority as Michael Garron, and Michael Garron seems to be the gold standard in terms of looking.

But is it based on the fact that you know what Michael Garron has accomplished, and you don't know what the others have? Or is the data available on all of them, and Michael Garron rose to the top?

ALLISON MCGEER: I think Ottawa has done -- I don't have data on the comparison to

Ottawa. I think Ottawa has done reasonably well. I think Hamilton is not doing badly, although they started behind in their organization, so I -- can I -- can I give you absolute data on numbers? No. Do I know that Michael Garron was the first organization to have vaccinated every institution in their area of responsibility by a margin of at least ten days? Yes.

COMMISSIONER JACK KITTS: Okay. And so we know a few have done extremely well. What do we know about the others in terms of where they're at? I think Dr. Stall was counting the number of doses sent out and the number that have been given. Is that a rough estimate of how we're doing? Or how do you -- how do you estimate how we're doing on the vaccine rollout elsewhere?

ALLISON MCGEER: Well, you know, one of the problems is we've been completely nontransparent about, right? There is no -- I have some information that I know that I can't talk about and some information that I know that I can talk about. And, you know, there is a complete absence of transparency about how well we are doing.

I think we -- somebody's told me

yesterday that the Province announced that we have completed vaccination of all long-term care homes in -- I'm not sure whether it was Toronto or whether it was the GTA. I think it was just Toronto. But really, I mean, one of our issues is that we have no -- there's been no transparency about what's going on and what we're doing.

And, in fact, you know, from my perspective, there's been a substantial politicization of the process, you know. When we were talking -- when prominent people were talking publicly about running out of vaccine ten days ago, we had more than a hundred thousand doses of vaccine in our freezers in Ontario.

You know, so this -- the absence of being able to figure out what's going on is difficult for everybody and I think not helpful in terms of trying to make sure that we're protecting people from death and ICU admission.

COMMISSIONER JACK KITTS: And where does the accountability lie in terms of making sure the doses that have been given out are given to the long-term care and the results given back to Ministry of Long-Term Care, or -- where is that?

ALLISON MCGEER: Well, it -- the --

I -- from my perspective, under normal circumstances, the responsibility for delivery of vaccination programs and reporting would belong to local Public Health units.

In this setting, the Ministry of Health, I believe -- although I'm having a little trouble navigating various organizations at -- in the Ontario Government -- the Ontario Ministry of Health removed that responsibility and placed it -- replaced it, I think, with the Vaccine Distribution Task Force on the Command Table. And at some stage in the last week of December, pieces of it were returned to different Public Health units in different ways, still not clear to me.

COMMISSIONER JACK KITTS: Right. So it would make -- yeah, so it would make sense that if this is a -- province-wide, that the 34 Public Health units would be responsible for ensuring that their area is covered, and that if there's only 19 hospitals, then those hospitals would have to share in areas where they needed more, and that the results should come back to Public Health so they could announce to the community --

ALLISON MCGEER: Yes.

COMMISSIONER JACK KITTS: -- we're

doing. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have the -- do you have the same impression that I do that, for some reason, there's an unwillingness to rely on the local Public Health units?

ALLISON MCGEER: Yes. I don't -- you know, I think -- so it is complicated by the Pfizer vaccine and the need for storage, but we could have -- we could have delivered -- we could have bought freezers for the Public Health units and had them run vaccination clinics, you know, had we chosen to.

We could have directed the hubs to work with their local Public Health units to deliver vaccine. You know, there are a number of things that we could have chosen to do that would have -- would have kept Public Health units involved locally.

And I think in places where Public Health and hospitals have -- a piece of the problem in Ontario is that everything is very local, so in many smaller areas, hospitals and public health units work well together all the time, and when the hospital hub got told to do something, they just

called their public health unit and said, okay. How are we doing this, you know, and people worked on it. In bigger places like Toronto in the GTA health units, that's much more difficult. And I think the responsibility was assigned initially to the hospital, and then some of it was transferred to Public Health, but the -- I don't think it was clear to anybody how that was supposed to work.

COMMISSIONER FRANK MARROCCO (CHAIR): Is this problem part of some larger struggle that's going on over public -- with public health units? Or is it just peculiar to the vaccine rollout? I don't want to get into the whole thing, but it just seems consistently the case that we'll use any method of dealing with these problems that doesn't involve -- that either duplicates or doesn't involve public health units, and I have some difficulty with that especially in a city like Toronto which is really just a collection of neighbourhoods. So -- and anyway, is that -- am I just reading too much into this? Or...

ALLISON MCGEER: I think one of our issues is that there is a lack of trust between our current Government and many local public health units, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

NATHAN STALL: I mean, I just wanted to be clear, though. I mean, when we talk about the slow speed of rollout, right, we had enough doses by the end of 2020 to vaccinate all long-term care home residents in our province. And --

ALLISON MCGEER: All long-term care and retirement home residents.

NATHAN STALL: Yeah, and retirement home residents. Yes. I know the Commission, you know, is technically overseeing long-term care, but, yes, and retirement home residents.

So -- and we are now into mid-January, approaching late January, and we still have not vaccinated the majority of these people despite the fact they contribute nearly 70% of deaths to date. And this is -- you know, there are innumerable jurisdictions now that have been able to vaccinate their entire long-term care home resident population who received vaccine at the same time that we did.

So this was not a supply issue at all, and the recent supply issues we have run into are very unfortunate, but we burn through the supply

vaccinating people who are at far lower greater risk of death. And that is a tough thing to contemplate when we know that we've had, you know, over 1,300 long-term care residents now die in the second wave since September 1st.

We know what the projections show that we are almost certainly going to eclipse the death toll from Wave 1, which was 1,815 long-term care residents. And we also know the -- even when you vaccinate people, there is a delay to when it starts to work, right?

So even if we vaccinate everyone now, you're still looking at a good 10 to 14 days before you have efficacy, and each day literally, when we have the amount of long-term care residents dying in our province, does mean lives.

And so this was -- you know, it was a slow speed, and there was a -- really, a perceived lack of urgency. I mean, we've spoken to people in Israel, for example, in terms of how they operated their long term -- their vaccination problem. They operated this on a 24/7 schedule and mobilized all resources to get it done because they knew that this was where deaths and cases were concentrated, and we have failed to do that so far.

One of the other things that really, I think, bothered Dr. McGeer and I was the initial resistance to work with the manufacturer to modify their very stringent requirements for transport, storage, and distribution. There were fears that not complying exactly with what the manufacturer had laid out in the product monograph with respect to the cold chain storage and the handling could jeopardize the supply chain.

But I have a hard time fully believing that knowing that many other jurisdictions were able to do this without any consequence to their supply chain. That would include provinces like Quebec and British Columbia, the States of California and Ohio, countries like Israel and the United Kingdom. This was done elsewhere, and it was done elsewhere in December. This was not done in Ontario until, I believe, the second week of January in Ottawa. And it's not as if we've had additional data that has come forward to suggest what, you know, we are planning to do in Ontario to move the product is safe in any way.

I just think it -- they worked with the manufacturers, as far as I understand, to get permission to move it, but not moving the product

into homes and not working to be able to modify the transport, storage, and distribution so that it had to remain within these 19 hospital hubs was -- also hugely slowed down the administration of the vaccine in our province in a really, really substantial way.

And that's another -- because we didn't have the Moderna vaccine, which is the one that can be moved. That didn't come until later in December, and a lot of that vaccine was also appropriately apportioned for remote and rural communities as well. And that Moderna is the vaccine that we have less supply of compared to Pfizer.

Anything else to add from that, Dr. McGeer?

ALLISON MCGEER: No. So I think the last thing that, as André Picard pointed out this morning, you know, we provided essentially no information to anybody who works in a long-term care sector about these vaccines.

We organized no education. We have a couple of FAQs on our website. They were -- they are relatively inaccessible. They are not translated. We did no push to the sector with

information about the vaccines, still very difficult to find copies of the officially approved provincial consent forms anywhere. We didn't say to long-term care facilities, you know, what we could have said in the middle of January, which was, this is going to be difficult. There are all sorts of challenges, so what we need you to do is we need you to get consent from all of your residents and substitute decision makers now.

We need to get -- you need to send this package of information to your substitute decision makers. You need to tell them that they either need to decide now or that they're going to have a very short timeframe because sometime between December 15th and January the 15th, somebody is going to call you and say, we can come and vaccinate your residents tomorrow; how many doses do you need? And you will need to be able to say, 78.

Homes do that all the time. It's normal function, the contact substitute decision makers to get consents from people. It's not that complicated. Everybody was waiting for vaccine, okay? But we had no communication with the long-term care sector homes over that time period

to talk to them about what was happening to get them information about the vaccine, to organize. You know, we've been dependent on academics to be organizing webinars for the people who live and work in long-term care to talk to them about potential risks and benefits. The -- a complete absence of any education or information program accompanied this rollout.

Now, as it turns out, okay, other people have stepped in, and people who live and work in long-term care understand how severe this is. And I don't think we're running into significant barriers.

I do, however, think I have -- I have never done webinars in which people have said nicer things about how grateful they are for information ever, okay? And so I don't know that it's changed the vaccination rate, but it would have made such a difference to how the workers in a -- after an extraordinarily difficult year feel about what they're doing and how they're managing things, and, you know, it's difficult to comprehend why we failed to do that.

NATHAN STALL: I agree. I --

COMMISSIONER FRANK MARROCCO (CHAIR):

Doctor, before you --

NATHAN STALL: Oh, sorry. Go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry, Dr. Stall.

Before you -- we leave that, the -- each long-term care home, when they admit someone, do they not go through a process to determine who the substitute decision maker will be and how to contact that person? Or...

ALLISON MCGEER: Yes, absolutely, and they contact those people routinely. They -- all -- every long-term care home has lists of email addresses and telephone numbers and alternate phone numbers and everything. And they can produce those lists at the drop of a hat, and they contact residents' families all the -- you know, if -- even in the setting where a resident can make their own decisions, a resident needs to go to the hospital, there's somebody in -- there's an emergency contact in the family that gets contacted. They -- long-term care homes, every time you make a medical decision for a resident of a long-term care home, you're contacting their substitute decision maker or somebody who's their emergency contact to help with it. That's a -- that's a completely routine

process.

COMMISSIONER FRANK MARROCCO (CHAIR): Would I be wrong in saying -- you were saying that nobody told them to get organized and contact the substitute decision makers where they're dealing with somebody who can't consent and figure out how many doses you need so, you know, so we make as efficient use of the supply as possible.

I -- where I have a bit of trouble is it seems to me that the homes -- I agree with you, they would have -- it would have been more appropriate for them to -- for this kind of instruction to be issued, but it also seems to me that they should know --

ALLISON MCGEER: So --

COMMISSIONER FRANK MARROCCO (CHAIR): -- that this is what we have to do in order to get our people vaccinated, so we may as well get on with it.

ALLISON MCGEER: So their problem is they're not vaccine experts. And in order to get consents, you have to send information about the vaccine to those substitute decision makers.

COMMISSIONER FRANK MARROCCO (CHAIR): I see.

ALLISON MCGEER: And it's got to be good, credible, expert information. And it -- I -- you know, I just don't think it's reasonable to expect -- I mean, all of us, okay -- so the Moderna product monograph with the -- you know, with the -- you know, there's two pieces of information about the Moderna that you needed for the consent form: The FDA -- the lovely, detailed stuff that the FDA had from December 17th, which was publicly posted, and the product monograph for Canada which came out on the 27th, Nathan, ish, okay?

And from that, you can -- you know, before you have that, it's really hard to put together the detailed information.

But you could have had a bunch of information that was set and ready to go, and then you could take the extra pieces from the Canadian product monograph and slot them in and send them out to people. That's what those homes needed in order to be able to talk --

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

ALLISON MCGEER: -- to their substitute decision makers to get organized.

COMMISSIONER FRANK MARROCCO (CHAIR): I

hadn't appreciated that. Thank you, Doctor.

NATHAN STALL: I think it was December 23rd, Dr. McGeer, that Moderna was approved.

ALLISON MCGEER: Yeah, but the -- for some reason, the product --

NATHAN STALL: Yes.

ALLISON MCGEER: -- monograph took a while. I don't know why.

NATHAN STALL: Yeah. The other piece to that -- so I totally agree. You know, the work that is being done to promote vaccine acceptance and education within the sector is all a bunch of grassroots, sort of, academics, community-based clinicians stepping forward, running pro bono webinars.

I mean, even the FAQ material that went out was material that Dr. Noah Ivers and I drafted over the Christmas break because we said, this is crazy that there's nothing actually out there, and we did that on our own time off the corner of our desk and sent it out to the Ministry.

And the other piece of this that was not completely considered but I know the associations have advocated for is work, sort of like Michael Garron did, to eliminate the

logistical barriers within the long-term care sector. So we knew that staff acceptance of vaccine was going to be an issue, and we also knew that we ought to have done everything to remove finances as a barrier.

So paying -- having homes, like Michael Garron did, pay for the time off that staff need to go get vaccinated instead of asking them to go on their off days and volunteer to go get vaccinated when they may have other jobs. Michael Garron provided transportation.

We heard it was intimidating for workers who may not live in downtown Toronto to come downtown and park near the vaccine administration centres, so providing transportation or payment.

And then additionally, you know, many people do get a sore arm afterwards. We know the jobs of personal support workers is quite physical, or they may have flu-like symptoms which causes them to miss work, and the failure to guarantee them paid sick leave for a day or two afterwards is another barrier that was not addressed completely as well.

So in addition to promoting acceptance

in a population that we know has a large -- or has a large -- or is very multicultural -- 40% of personal support workers are visible minorities -- we did not tailor any strategies to promote acceptance in this population and remove financial barriers as well.

ALLISON MCGEER: There are some places outside of the GTA where people would have had to spend an hour and a half or two hours driving to the hub to get their --

NATHAN STALL: Yeah.

ALLISON MCGEER: -- vaccine.

COMMISSIONER FRANK MARROCCO (CHAIR): And some of these long-term care homes took the attitude that this was -- you need to go on your day off to get the vaccine? I mean, wouldn't it -- wouldn't it -- it would have seemed to me it's just a matter of sound public health practice that if you're working with people who are highly prone to die from this disease and you can be insulated from conveying it, that that's just a matter of public health. I mean, you have to go and get it or somebody has to assess whether they want to continue to hire you, but that's all time you're -- that's work time, I would have thought.

ALLISON MCGEER: Remember, we're asking long-term care workers to come in on their days off to get their weekly swabs done now.

NATHAN STALL: And remember also --

Oh, sorry, Commissioner Coke, just --

Remember, we all -- the reason that the General justified closing the vaccine clinics on the statutory holidays over Christmas was they didn't want to ask the workers to come on their holiday days off which they were going to be unpaid for to come get their vaccine. So, you know, that was publicly stated as well which is the reason why they closed the vaccine clinics over holidays.

So they -- I mean, that was an admittance that, you know, they were asking people to come on their days off, and then here, they didn't want them to ask them to come on their days off on the holidays.

Sorry, Commissioner Coke.

COMMISSIONER ANGELA COKE: We were just hearing from an operator from another home that, you know, they had been advocating to be able to do the vaccinations themselves at the homes, and just interested in your thoughts about that.

ALLISON MCGEER: You know, in October,

in the middle of the second wave, every long-term care facility in Ontario delivered high-dose flu vaccine to 90% of residents. These homes -- and that was at a time when people were more than usually short-staffed, when there was a lot of stuff going on. It was not easy, okay? Homes run those vaccination programs all the time.

In the middle of December, I got a call from one of the homes saying, okay, so we're getting ready for vaccination programs. Do we have to order needles and syringes and, you know, alcohol swabs and Band-Aids? Or is that coming with the vaccine because we don't want to create a run on those things if we don't need them, but we want to be ready for vaccine.

And I sent that up the chain to as many people as I could find. I never got an answer, okay, because we -- well, that's not true, okay? I -- you know, I found out several weeks later that, you know, everything was coming with the vaccine, that people had that organized.

But we didn't need to do that, okay? That's a bunch of work that got done at the Provincial Government level ordering things that didn't need to be done. We just needed to say to

nursing homes, you need to have stuff ready. We could have delivered the Moderna vaccine the day after it arrived on December 30th to all those nursing homes, and had we done that, we could have vaccinated half of the residents in long-term care in the province that some -- we had about 50,000 doses of Moderna available, okay; 77,000 long-term care residents, we could have done 50,000 of them on that weekend if we'd just given nursing homes information to get consents and enough information about when they were getting the vaccine.

We chose to create a separate system in which other people are vaccinating residents of long-term care instead of using the system we already had which works beautiful.

COMMISSIONER ANGELA COKE: Thank you.

NATHAN STALL: And I think the last point before I move on to the next slide is, as I'll show you, one of the things which I think people are justifiably outraged about is that they have only prioritised 4 of the 34 public health units as "priority regions" for vaccination of long-term care homes by a deadline of January 21st, and that's Toronto, Peel, York, and Windsor-Essex. And there are homes, and there are regions, like

Niagara Region, where they have not vaccinated, as I understand -- because their Moderna supply was recently diverted -- nearly a single long-term care home resident. I think they're just starting to do it now. But this created huge regional inequities as well, and as I'll show you, especially for long-term care homes, you know, every -- many of the regions were priority above and beyond those four. And only a third of the out -- long-term outbreaks that are currently going on in the Province are actually in those four priority regions. And so there were many residents who were left vulnerable and did not receive vaccine because only these four regions were prioritised.

COMMISSIONER FRANK MARROCCO (CHAIR): If it's not --

JOHN CALLAGHAN: Can I ask a question, Dr. Stall? Oh, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Just -- sorry, Mr. Callaghan.

If it's not the severity or the prevalence of the disease, do you have any sense of what the criteria were that led to the selection of the four regions?

NATHAN STALL: I mean, these were

termed -- they went after the old tiered, coloured framework where they were looking at regions that were in the highest gray or the gray zones where there was the highest levels of the community transmission.

You know, those homes are going to have outbreaks, and, you know, they clearly are the regions with the highest levels of community transmission, but the point being that there were and continue to be several devastating outbreaks across different Public Health units.

And I think when you're talking about -- you know, one of the things that happened when we talk about the politicization was when the Government -- or when the Task Force responded to the outcries of vaccine clinics being closed over Christmas, the General gave instructions -- the retired General Hillier gave instructions to favour "speed over precision," and that speed "trumps perfection."

But, you know, we're dealing with a very -- a relatively very small population, 70,000, you know, is the current occupancy out of the 77,000 beds, so 70,000 residents. And to date, this population has accounted for only two-thirds

of all deaths. And so I think some more precision here and not relying on what the priority regions are for the larger community transmission across the Province would have prevented a lot of cases and a lot of deaths.

And so I disagree here that, you know, speed was not the way to go, especially when we have run into the issues that we are now seeing with supply.

JOHN CALLAGHAN: Can I -- can I ask you, Dr. Stall, this is something we obviously could find, but maybe you know: What is the -- what is the current daily infection rate amongst long-term care residents? Do you have an idea?

NATHAN STALL: Like, how many active infections are there, or how many new residents are --

JOHN CALLAGHAN: How many residents are being affected a day?

U/T NATHAN STALL: I'd -- I could pull that up and send that to you after the meeting. I don't want to misquote the data.

JOHN CALLAGHAN: Okay. But is it still a situation that 20 to 30% of those infected die?

NATHAN STALL: Yeah, the case fatality

rate is a little lower than the 30% from the first wave. It's closer to 20% now in the second wave, but, yes. And we have -- for the last month, we've had somewhere -- you know, the way the Province reports the data is active infections as opposed to new infections. We can always calculate that and get that to you, but we've had somewhere between 1,200 to 1,600 active long-term care resident infections per day over the last month.

JOHN CALLAGHAN: So a fifth of those are likely to die?

NATHAN STALL: Yes.

JOHN CALLAGHAN: Okay. Thank you.

NATHAN STALL: All right. I'm going to just show you the modeling that we did, and I'll go quickly for this so we can discuss what we think needs to be done now.

So, you know, the Province has put out -- these are three scenarios we modelled, and I'll show you how we did this. All long-term care residents being provided the first dose by January 21st, so that's two days from now, and that, to be clear, would have been over a month from when we received the first vaccine or when we administered the first vaccine in our province which was

December 14th.

A second plan of all long-term care residents being provided the first dose by January 31st, and we are assuming that the long-term care residents in those four priority regions will receive their first dose by January 21st as the Province has indicated. So the four PHUs will -- the residents in the four PHUs will get it by Jan 21st. Some of them -- and then the rest of them will get it between the 21st and the 31st for the purpose of this modeling.

And then the current plan, which is to vaccinate all residents in the four priority regions by January 21st, and the rest of the residents in the Province by February 15th. That's the current Ontario plan. So we modeled these three scenarios.

And just to confirm, and this gets at, sort of, what Mr. Callaghan was ask -- or getting at, there are -- two date, there have been 13,000 cumulative SARS-CoV-2 long-term care residents infections in the Province. We've had 3,212 cumulative deaths. This was as of January 17th, and that's almost 60% of Ontario's total 5,433 COVID-19 deaths.

The rollout began on December 14th, and looking at the priority key groups as well as aligning with the ethical framework, they did prioritise long-term care residents as a key group for the distribution of initial COVID-19 vaccines.

We know that recent updates from the technical update, and I believe there's actually one going on now, but there was a technical update last week that they targeted Jan 21st as the date to provide those first doses in the four priority regions of Toronto, Peel, York, and Windsor-Essex. And I pulled the data on this as of January 17th, so those priority regions only account for a quarter of Ontario's long-term care homes, a third of the licensed beds, and 30% of currently occupied beds, and only 39% of Ontario's active COVID-19 long-term care home outbreaks are occurring in those four priority regions as of Jan 17th.

So this is not covering -- when I led by saying, you know, Alberta has vaccinated all their residents; Quebec as done 75% of residents; British Columbia will finish by end of next week, and we've had other jurisdictions like West Virginia that actually did this by the end of December in the State of West Virginia, so just to

show you how unambitious this plan of January 21st is in terms of vaccination.

We used a model that the Ministry of Health has been using since the beginning of the pandemic when this model was calibrated which forecasts COVID-19 cases and deaths, and we forecasted this in a scenario of no vaccination so that we could compare what the effect of those three vaccination rollout scenarios were on the vaccine preventable cases and deaths.

So this model is a -- called a compartmental model. It has three parts to generate the number of predicted cases over the ensuing weeks. The first is based on community and COVID-19 infection rates, the model predicts how many homes will have outbreaks.

The second step, it predicts which specific homes will have COVID-19 outbreaks based on the number of homes it predicted.

And then the third is, within each of those homes, it predicts how many COVID-19 cases and deaths will occur. And then this model is recalibrated on a -- on a weekly basis in the Province based on the community incidents and what's going on inside the long-term care homes.

So we use this existing model, and we put in some assumptions about vaccination in these three rollout scenarios.

So just to be clear, the assumptions we made were that all residents will be vaccinated with the Moderna vaccine. We could have done the split with the Pfizer vaccine, but frankly, for the -- for the purposes of this, the efficacy is pretty similar and would not have made a difference on the principle findings.

And you'll see the vaccine efficacy, you actually get 94% vaccine efficacy in the clinical trials after -- from 14 days and onward. And that's why we're so -- Dr. McGeer and I are so disturbed by the fact that we have taken so long to vaccinate the long-term care home resident population.

We made the assumption that the -- for the purpose of this modeling, the vaccine efficacy will be the same in the Ontario long-term care resident population as it was in the published clinical trials. We assume that uptake will be a hundred percent and that between the rollout scenario, so January 21st, January 30th, and to February 15th, the speed is linear, so we equally

balance out which homes get vaccinated, and a random order of homes get vaccinated.

And then, also, long-term care residents who were previously infected on or after September 1st, 2020, so the start of the second wave, are conferred a hundred percent immunity.

And so this was the assumptions in the model, and here's what we show. So this is -- this is the -- on the 'Y' axis, the preventable long-term care resident cases in the three scenarios.

So January 21st, you vaccinate more people, and you're looking until March 31st. From current date, what you start to see from -- or from Jan 21st, this is, again, compared to a scenario where no one is vaccinated, so if you get all the long-term care residents done by January 21st, you can -- and I'll show you the uncertainty intervals -- you can prevent about somewhere around 3,700 cases. If you delay ten days, you can vaccinate about 3,000 cases. And if you follow the Province's current plan, you can prevent about 2,000 cases, so you can start to calculate the difference in cases you prevent the longer you delay vaccination of the whole population.

This is the deaths, so again, January -- this is the number of preventable deaths. So you vaccinate everyone by Jan 21st. You prevent around 750 deaths. You vaccinate by Jan 31st, you prevent about 600 deaths, and you follow the Province's current plan, you prevent about 400 deaths all compared to a situation of no vaccination.

So to summarize, in these three scenarios, Jan 21st, you prevent 3,700 cases, 750 deaths. Jan 31st, you prevent 3,000 cases, 600 deaths, or the current plan -- sorry, that's -- that is a typo there in the -- in the slide deck in terms of preventable cases here. Let me just pull the exact number for you so that you -- I present what -- it's 380. Sorry about that. You present three -- you prevent 380 deaths in the current plan that Ontario has.

So and again, in all these three scenarios, we are assuming that the long-term care residents in the four priority regions will be vaccinated by January 21st. So you can see if you compare the plan of vaccinating from Jan 21st compared to the current plan of February 15th, you can see the difference in the deaths between 750

prevented deaths to 380 prevented deaths, so that --

COMMISSIONER FRANK MARROCCO (CHAIR): So in other words, twice as many people --

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- will die.

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): If you're target date is February 15th --

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- than would have died if your target date had been January 21st.

NATHAN STALL: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

NATHAN STALL: So, yeah, and that's summarized here. That's summarized here. So we -- you know, the key messages are the model's designed to predict these long-term care home outbreaks. We can also use them to predict the impact of vaccination. So look, I showed you -- I've compared it here to Jan 31st, which is, you know, 12 days from now. I think Dr. McGeer would agree

that if we put our mind to it and our efforts to it, we could vaccinate every single resident. We could probably do it by January 21st, but, you know, if we did that, we'd save 220 lives compared to the current schedule.

If we vaccinated all long-term residents by Jan 21st, we would prevent a total of 370 deaths. So -- and then again, you also are going to prevent a lot of cases which are going to be outbreaks, then which require a lot of resources to manage these outbreaks, right?

So it's not just the deaths that you're preventing -- and the cases do have long-term care morbidity on these residents as well. And they require the resources from Public Health and hospitals and within the homes to manage these outbreaks. So this speaks to -- not to convince you of that -- the extreme urgency of doing this as soon as possible.

COMMISSIONER JACK KITTS: Dr. Stall, can I ask a question about the modeling?

NATHAN STALL: Yes.

COMMISSIONER JACK KITTS: Is this -- is this modeling that, you know, physicians and scientists like you and Dr. McGeer agree on that

this is -- this is relevant in terms of reality?

Or do people argue with this and say there are other models or disagree with your findings? Like, how well accepted is this in the scientific world, and are there other thoughts?

NATHAN STALL: I mean, frankly, I don't think this is something you actually need to model. I think it's common sense. So -- you know, so we did it to provide data to provide a further push towards doing what we think needs to be done.

Are the numbers of cases and deaths going to end up exactly the same way? No. But does it show, you know, how many lives we're leaving on the table with a slow rollout potentially, you know, within the ballpark? I think it does.

Will there be critics of the model and exactly what went into the model and the assumptions? Yes. But I don't think anyone would argue with the face validity of it that the longer you delay vaccination, the more cases of deaths you're going to have.

COMMISSIONER JACK KITTS: Okay. And this would be discussed at Public Health Ontario, the Chief Medical Officer of Health. This is

all -- would be known to them?

NATHAN STALL: We have shared this modeling last week, and it was shared with the Distribution Task Force, and this modeling will come out within an evidence brief through the science -- COVID-19 Science Advisory Table within the next 48 hours. But it has already been shared with key decision makers.

ALLISON MCGEER: Yeah. And I would point out to you, this is not -- you don't need to do this modeling to see that first dose into resident arms in long-term care will save lives. You know, I -- it -- the modeling is very helpful, I think, in terms of understanding what the numbers look like and what the limits are, it has been, I think, the science table work and the modeling's been really helpful in convincing people of it.

COMMISSIONER JACK KITTS: Okay.

ALLISON MCGEER: But honestly, the problem is really simple.

COMMISSIONER JACK KITTS: And just if we go back, we don't know how many staff, residents, and caregivers in our long-term care homes in Ontario have been vaccinated today.

NATHAN STALL: We do in -- so we have a

COVAX -- it's called COVAX, C-O-V-A-X, system --

COMMISSIONER JACK KITTS: M-hm.

NATHAN STALL: -- which is the electronic repository for all of this. The issues have been that -- I mean, the system was created, to their credit, in ten days. I mean, we could have argued we could have been planning ahead to create the system.

But when they go to these homes, it's operationally -- and I've been to a home -- two homes to vaccinate. It's -- operationally, it takes too much time to enter the data in real time into the system, so many homes input it onto paper records which then need to be inputted electronically after, so there are real delays in that.

There were also technological glitches that delayed this going up, and, additionally, the data has not yet been claimed by public health Ontario so that we understand -- so that we can specifically make sure that this is accurate and reliable data. And as I understand it, Dr. McGeer may have heard this as well: Initially, the essential caregiver field was also omitted on the COVAX program, so you have to make some assumptions

about who's a resident versus who is a staff -- like, they'll have resident staff, but the caregivers are also mixed into there, so...

COMMISSIONER JACK KITTS: Right.

ALLISON MCGEER: Yeah. I think it's also the -- there's -- the -- there's healthcare workers in long-term care homes, and there's other workers in -- and the other workers are grouped in long-term care retirement, so you can't -- it makes it -- even for people who have access to the data, it makes it difficult to assess how well we're doing with workers in long-term care homes.

My understanding is that the Ministry has, I think, last week, started to ask long-term care homes to report daily on how many of their residents and staff are vaccinated so that we get some -- or so that they get some interim data on actual vaccination rates while COVAX catches up. I think COVAX is doing pretty well for a system that didn't exist a month ago, but it's -- you know, it's clearly behind.

To me, a piece of the bigger issue is that these data -- that you don't have access to these data. There is no reason on earth that the people of Ontario should not know how well we're

doing with vaccinating long-term care.

And I get -- you know, I get the issues. I know we're behind with who got Moderna vaccine in long-term care facilities. But, you know, Public Health data always come with provisos. The fact that there are a bunch of issues with the data does not mean that what data we have are not good, and does it not mean that we should not be sharing with people and talking about targets. And the complete absence of transparency on how we're doing with our vaccination program and what we're doing with our vaccination program, I find really distressing.

COMMISSIONER JACK KITTS: So the COVAX data may not be as pure as it -- we'd like it to be, but it is reflective of what's happening. And --

ALLISON MCGEER: Yeah, for sure. And we know what the holes are.

COMMISSIONER JACK KITTS: Right. And that COVAX data is known to one of the tables, the command tables?

ALLISON MCGEER: I don't know. It is known to people at the -- it is known to people in government and to a fairly large number of people

advising government who have signed confidentiality agreements for one reason or another.

COMMISSIONER JACK KITTS: And you and Dr. Stall are advocating that the data, regardless of the fact it may not be as pure as we would like, should be public?

ALLISON MCGEER: Yes. I think we -- I think we need to know. I see no reason why people should not know how well we're doing, and I think knowing how well we're doing will help everybody in the system understand what's going on and manage what's going to be happening in vaccination program better in the next few months.

COMMISSIONER JACK KITTS: Thank you very much.

NATHAN STALL: Yeah, I think the absence of data contributes to the mistrust and the feeling of a lack of transparency about what's going on with the rollout.

ALLISON MCGEER: It's also about uncertainties, right? I -- you know, if I -- if I don't -- if I'm a retirement home and I don't know what the government is planning or when vaccine might be coming to me or where we are in the schedule, and people know that to varying degrees

from their public health units, but it's still the -- the more open we can be about the process and what's happening, the more reassured people will be, I think, about the fact that we really are moving heaven and earth to get this done even if we have failings.

COMMISSIONER JACK KITTS: Okay. Thank you.

NATHAN STALL: So, Dr. McGeer, do you want to speak about what could have been done? I know we've spoken to a lot of this, but just to summarize this.

ALLISON MCGEER: I think we've been through most of it. The issues to my mind are that we have had inadequate communication about how to manage it. We have been, I think, unwilling to use existing systems that work very well to deliver our vaccination program, and we -- the appearance is that we missed the fact that we were running a vaccination program in the middle of a pandemic, and we just didn't fully grasp the impact that, really, a vaccination was going to have on the number of cases and the number of deaths in the sector.

NATHAN STALL: So -- and, Doctor, do

you want to speak about what we could do now?

ALLISON MCGEER: Yeah, so I -- so, you know, I don't know how useful this is because this is -- this is very short term because we're sitting now facing a limited amount of Moderna vaccine coming in and some drop in the number of Pfizer doses. And so the question becomes, okay, if we have a limited number of doses and if we want to do the best we can, we've all agreed that we're aiming at long-term care and retirement.

We -- what the Province, I understand, is doing is they -- they're suspending second doses of vaccine to hospital-based healthcare workers, but they -- and they're trying to switch everything over to long-term care and retirement.

I think there, then, is a list of short-term things we could do to try to do better. The first is, you know, suspending -- allowing long-term care workers to get their second dose, but not acute care hospital healthcare workers get their second dose of hubs is maybe not a bad idea except that long-term care workers are likely well protected for several weeks by the first dose, so they don't need it in the first place.

And in the second place, I think asking

hospital hubs to operationalize that difference and to distinguish between where people work and get it right is just unnecessarily complicated in the short term. So that if we just said, no more second doses at hospital hubs for two weeks, right? This is not a -- this is not a, you don't get your second dose. This is a, you get your second dose later when Pfizer finally catches up next month, okay?

Many long-term care residents and staff have been previously infected. We've been vaccinating them. It's a good idea. It's -- it adds complication to remove them from the system, and vaccination is probably good for them. But we could now say, okay, we're really saving doses. We know which residents have been infected. We ask staff not to get the vaccine and wait on their second dose means we have to be able to pick them up later, but likely possible.

We've now got a substantial number of residents, staff, essential caregivers, who got their first dose of vaccine and then got infected. And those people don't need their second dose in the short term, and we could delay their second dose.

We have an opportunity -- we have studies running in the province looking at the immune response to the first dose in residents. We're organizing to get data so that we can look at how well people are doing prior to the scheduled second dose of vaccine.

I think the data up to day 14, which is about how long we've had from first vaccine to infection now, is mixed. But in two weeks, we will have a very good idea of whether this vaccine is -- after a first dose is working as well in residents of long-term care as it is in the people in the trials. And we really have -- we really have no idea now whether or not that's true.

If it is working well in those residents, then we could, by agreeing to delay vaccine in those residents by five or six days, we could watch what happens. And if they're doing well, we could divert all those second doses into the rest of retirement home [sic] across the Province. I do understand how complicated this is, and it -- maybe this is imaginary, but it -- we could do that if we chose to. And there is no question that if this vaccine works well, and if people don't need their second vaccine, that we

could prevent deaths. Looking at Nathan's modeling, I don't know, maybe 50 or 60 deaths by doing that across the Province.

So, you know, I -- I'm still hoping -- I'm still hoping that the Province can be moved to try to optimise the situation we're in in the short term to protect long-term care residents. I'm -- I don't know how to make it happen. I'm not sure it's going to.

NATHAN STALL: So that's -- yeah, that concludes what we had prepared, and we'd be happy to take questions.

Yes, Commissioner Kitts.

COMMISSIONER JACK KITTS: Can we go back to, What We Do Now, just the previous slide? So in Recommendation Number 1, am I to assume that hospital hubs are the distributor for the vaccine now for an area defined -- I don't know -- defined by Government so that when you say suspend all second dose of vaccine at the hospital hubs, you're saying if the long-term care homes are actually administering the vaccines, they would -- they would hold off until -- I don't know -- what, 28 days or -- I'm just not clear what that really means what we would do now.

ALLISON MCGEER: So we're running -- we're running -- we're delivering vaccine in two ways now. We have hospital hubs that are running vaccination clinics at the hospital hub, and then we have vaccination teams that are going out to vaccinate long-term care residents and retirement home residents.

So that -- at the hospital hub -- yesterday, we gave nearly 4,000 second doses of Pfizer vaccine in those hospital hubs. And that's all healthcare workers, okay? That's none of them residents. It's mixed. Some of those healthcare workers are long-term care. Some of them are acute care. Some of them are essential caregivers, so there's a -- there's a range of workers there.

But if we just suspended that for -- it's probably -- we're going to be three or four weeks behind with the Pfizer doses, so we'd have to say instead of giving you your second dose at three weeks, for Pfizer, we'd be giving your second dose at six weeks for Pfizer probably by the time we caught up.

And we -- at the moment, my understanding is what hospitals have been told is they are suspending the second dose for acute care

hospital healthcare workers, but they are maintaining the second dose for long-term care workers.

And to me, that's a nice concept, but it's too complicated, and it uses doses in -- for long-term care workers that are not effective. And honestly, you know, three weeks from now, those long-term care workers will probably get vaccinated at the homes where they work which is a lot easier for them, and, yeah.

COMMISSIONER JACK KITTS: So isn't part of that recommendation is, you know, convert hospital hubs into distributors to long-term care homes so long-term care homes can vaccinate their own staff, residents, and caregivers?

ALLISON MCGEER: Yeah, that's what we should be doing. I don't think -- I -- like, I understand that even this slide is magical thinking, but there's magical thinking, and there's things that are clearly impossible.

COMMISSIONER JACK KITTS: So long-term care homes who do this every year for flu vaccines, we're hesitant to let them do it with this one?

ALLISON MCGEER: Yes. And I don't think -- so I think there are two issues with that

now. The first is, we've set up a system in which they're not doing it. And now we're talking about changing horses midstream which is to go to long-term care homes after we've told them that we're sending them vaccination clinics, and people are coming, and they aren't supposed to do anything except get consents, and to switch them over now and to say, okay, next week, you're responsible for running your vaccination program, is, I think, suboptimal at the moment.

And we do have a lot of volunteers for these vaccination clinics. I think they're actually working pretty well, so I don't think we should be changing that at the moment until we get through this. It's not what I think we should have done, but I think it's too late to change.

COMMISSIONER JACK KITTS: Yeah. Yeah. I think you've put it well. What we should have done is -- didn't happen, so what could we do now? And you're saying the least of -- the least of two evils would be to continue with the course as opposed to trying to change in midstream.

ALLISON MCGEER: I think so.

Nathan?

NATHAN STALL: Well, continue with the

course, but substantially accelerate it.

ALLISON MCGEER: Yes.

NATHAN STALL: Substantially accelerate it. Like, we should be vaccinating 24/7 because when you see the deaths, you see the cases, you know, it is averting a plane crash if we get this done, and, you know, we are leaving our best defence either in the freezer or putting our best defence into the arms of people who are less likely to die. And, yeah, the urgency cannot be understated.

COMMISSIONER JACK KITTS: Thank you. That's well-stated.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I don't think we have any further questions.

Mr. Callaghan, do you have any questions you wanted to ask? Apparently not. He's speaking but he's on mute.

JOHN CALLAGHAN: No. I'm sorry. I was on mute. I didn't want to disrupt the proceedings. No, but thank you to both doctors for this short-notice presentation.

COMMISSIONER FRANK MARROCCO (CHAIR): This is very informative. I suppose it speaks, in a way, to what you were saying, but I think we were

genuinely wondering about this, and this is very helpful for us to have. And thanks again. Thanks for -- you know, generally, thanks for your cooperation with the Commission. It seems every short period of time we ask you to come back and tell us something else, and we do really appreciate your time and energy. We know you've got lots of things to do. So thank you.

ALLISON MCGEER: Thank you.

COMMISSIONER JACK KITTS: Yes, thank you both. Thank you.

NATHAN STALL: Thank you.

COMMISSIONER ANGELA COKE: Thank you.

U/T NATHAN STALL: And I will send you just the corrected slide with that number so that you have the final version.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

COMMISSIONER JACK KITTS: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you.

-- Adjourned at 11:35 a.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 20th day of January, 2021.

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